

Healing Hands Chiropractic, LLC

3 Hall Ave, Wallingford CT 06492 (203)626-9994

AUTO INJURY QUESTIONNAIRE

Name _____ Age _____ Birth Date ____/____/____
Sex: M F
Address _____ City _____ State _____ Zip _____
Home# _____ Cell# _____ Work# _____
Email _____ Who referred you to us? _____
Marital Status M S D W Number of Children _____ Are you Pregnant? Yes No
Height _____ Weight _____ Occupation _____ Full Time / Part Time
Employers Name _____ Employers Address _____
Your Auto Ins. Co. _____ Policy # _____ Agents Name _____
Do you have Med Pay on Policy? Yes No Unknown Do you have health insurance? Yes No
NATURE OF ACCIDENT: 1. Date of Accident ____/____/____ 2. In your own words, briefly describe the
accident: _____

3. Were you Driver Front Passenger Left rear passenger Right rear passenger Other _____
4. Who hit who/what? You hit other vehicle Other vehicle hit you You hit object _____
5. Point of impact Head-on Left Front Right Front Rear-End Left Rear Right Rear
5a. Damage to your vehicle: none mild moderate severe totaled
6. Your vehicle type Car Van Station Wagon Pick-up truck SUV Other _____
7. What was your vehicle doing at the time of the accident? Stopped at an intersection
 Stopped in traffic Stopped at light Making a right turn Making a left turn Parking
 Proceeding along Slowing down Accelerating (what speed were you going) _____
 Other _____
8. The other vehicle type Car Van Station Wagon Pick-up truck SUV
 Other _____
9. What was the other vehicle doing at the time of the accident? Stopped at an intersection
 Stopped in traffic Stopped at light Making a right turn Making a left turn Parking
 Proceeding along Slowing down Accelerating(what speed were they going) _____
 Other _____
10. Did you have a seat belt on? Yes No
11. What was the direction of your head at time of impact? looking Straight Turned Right
 Turned Left
12. How many people were in the car with you? None One Two Three Four Other _____
13. Time of Accident _____
Road conditions at time of accident Icy Wet Sandy Dark Clean and Dry
14. Visibility at time of Accident Poor Fair Good
15. What was the position your headrest at time of impact? Up Down Unknown N/A
16. Did your head hit the headrest? Yes No Unknown
17. Did driver side air bags deploy? Yes No Did passenger side airbags deploy Yes No
18. What was your hand position on the steering wheel? Both hands on One hand on Don't recall

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19. Did you feel any of these symptoms following impact? ___disoriented ___discomfort ___tightness ___frightened ___stunned ___loss of consciousness ___went to hospital

Immediate pain please list _____

20. Did you have pressure on the brakes? Yes No Do not recall

21. Did you see the accident coming? Yes No Were you braced for the impact? Yes No

22. Did your body strike the inside of your vehicle? Yes No

*If yes, what part of your body? _____ hit what part of the vehicle? _____

23. Did your vehicle hit anything else after the crash? _____

24. Did you lose consciousness during the injury Yes No *If yes, how long _____

25. Did the police show up at the scene? Yes No Was a report filed? Yes No

26. Where did you go after the accident? Home Work Hospital ER Private Doctor

27. How did you get there? Drove self Somebody else Ambulance Police

Other _____

28. Check off your symptoms right after and/or a few days following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hand numbness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Neck stiffness |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Toe numbness |
| <input type="checkbox"/> Sleep trouble | <input type="checkbox"/> Fainting | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Pain behind eyes | |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Loss of smell | |

29. If you went to the hospital, were x-rays done? Yes No Was lab work done? Yes No

Body parts x-rayed? _____ X-rays revealed? _____

Lab work revealed? _____

30. Treatments: Cervical collar Ice Medications _____ Other _____

Primary Complaint: _____

Symptoms appeared: Gradually Suddenly Is this pain due to accident? yes/no

How long have you had this pain? _____ Years / Months / Weeks / Days

Is it getting: better worse same

Mark an X on the picture to the right where you are having pain or discomfort --->

Type of pain: Aching Burning Diffused Dull Numbness Sharp Shooting Throbbing Tightness

Tingling

How frequently do you have this pain? Constant Frequent Intermittent Occasional

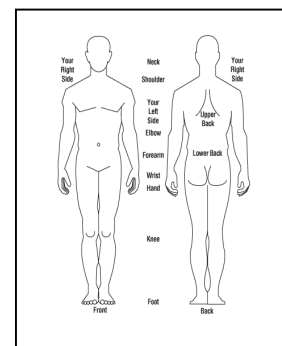
Symptoms are aggravated by: _____

Symptoms are reduced by: _____

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10 at worst/at best

What time of day is the pain most noticeable? _____

Does it keep you from sleeping? Y/N



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Secondary Complaint: _____

Symptoms appeared: Gradually Suddenly Is this pain due to accident? yes/no

How long have you had this pain? _____ Years / Months / Weeks / Days

Is it getting: better worse same

Mark an X on the picture to the right where you are having pain or discomfort --->

Type of pain: Aching Burning Diffused Dull Numbness Sharp Shooting Throbbing Tightness
 Tingling

How frequently do you have this pain? Constant Frequent Intermittent Occasional

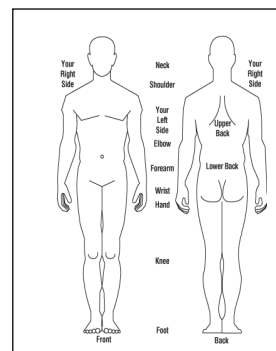
Symptoms are aggravated by: _____

Symptoms are reduced by: _____

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10 at worst/at best

What time of day is the pain most noticeable? _____

Does it keep you from sleeping? Y/N



Third Complaint _____

Symptoms appeared: Gradually Suddenly Is this pain due to accident? yes/no

How long have you had this pain? _____ Years / Months / Weeks / Days

Is it getting: better worse same

Mark an X on the picture to the right where you are having pain or discomfort --->

Type of pain: Aching Burning Diffused Dull Numbness Sharp Shooting Throbbing Tightness
 Tingling

How frequently do you have this pain? Constant Frequent Intermittent Occasional

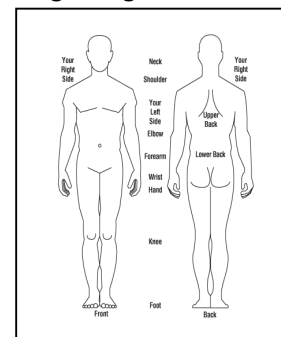
Symptoms are aggravated by: _____

Symptoms are reduced by: _____

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10 at worst/at best

What time of day is the pain most noticeable? _____

Does it keep you from sleeping? Y/N



Additional Complaint: _____

PLEASE LIST ALL SURGERIES YOU HAVE HAD

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION? _____

Physicians or health care practitioners seen:

Name _____ 2) Name _____

Phone # _____ Phone # _____

Dates of care _____ Dates of care _____

Tests/Treatments _____ Tests/Treatments _____

Results _____ Results _____

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PLEASE LIST ANY PREVIOUS ACCIDENTS/FALLS

What _____ When _____

What _____ When _____

Remarks _____

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

Prior Similar Symptoms: Has your history contributed to your current symptoms

- | | | |
|---|---|---|
| <input type="checkbox"/> I have NOT had prior symptoms similar to my current complaints | <input type="checkbox"/> My history HAS NOT contributed to my current symptoms | My most recent prior similar symptoms (if applicable) occurred...
<input type="checkbox"/> Months ago / <input type="checkbox"/> Years ago or on date: ___/___/___ |
| <input type="checkbox"/> My history HAS contributed to my current symptoms | <input type="checkbox"/> My current complaints ALREADY existed and were worsened | |
| <input type="checkbox"/> My current complaints DID exist before, but have not been bothering me | <input type="checkbox"/> I'm NOT SURE if my history has contributed to my current symptoms. | |

Write in any prior symptom history, not covered above:

Please check all conditions below that you currently have or have had in the past

- | | | | | |
|---|---|------------------------------------|---------------------------------|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sinusitis | | <input type="checkbox"/> Breast Lump |
| <input type="checkbox"/> Heartburn/Acid reflux | <input type="checkbox"/> Appendicitis | | | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Diarrhea | | | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Herniated Disc | | | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Mumps | | | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Sleeping Problems | | | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | | | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Difficulty Swallowing | | | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Herpes | | | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Nervousness/Anxiety | | | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Thyroid Problems | | | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Asthma/Short of breath | | | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Dizziness | | | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> High Blood Pressure | | | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Osteoporosis | | | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Tonsillitis | | | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Bleeding Disorder | | | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Eating Disorder | | | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> High Cholesterol | | | <input type="checkbox"/> Polio |
| | <input type="checkbox"/> Pacemaker | | | <input type="checkbox"/> Vaginal Infections |

Any other conditions not listed above: _____

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OCCUPATIONAL INFORMATION

Do any of your work activities aggravate your present main complaints? Please describe: _____

Job Involves: Sitting Standing Desk Counter Other _____ How long? _____

Lifting How much weight? _____ Bending Stooping Twisting Turning

Type of shoes High heels Boots Arch supports Other _____

How long do you speak on the telephone each day? _____ Traditional telephone receiver Headset

Physical activity at work: Sedentary Light manual labor Manual labor Heavy manual labor

HOW HAS THIS AFFECTED YOUR LIFE?

Circle one Have you missed work? YES NO If yes, how long? _____

Has the quality of your work been affected? YES NO Are you able to do household chores? YES NO

Has this problem interfered with your social life? YES NO

Has it interfered with spending time with family and friends? YES NO

Has it interfered with your recreational activities? (Exercise, Golf, Tennis, etc.) YES NO

Please List: _____

Please list any other daily activities/duties that are difficult for you due to the pain you're having.

DISABILITY

Do you have a permanent disability rating? _____ Location _____

Date received _____ Rating Percentage _____

HEALTH HABITS:

Smoking: _____ Packs per Week

Alcohol: _____ Drinks per Week

Coffee/Caffeine: _____ Drinks per Week

Other Chemical _____

Dependencies: _____

High Stress Level: High/ Moderate/ Low

Reason: _____

Exercise: None Moderate Daily

Heavy Sleep: Hours per night _____ Type of

mattress _____ Naps _____

Do you sleep on your Back Side Stomach

Please describe your sleep (ex. deep/restful, interrupted, etc.) _____

Any special diets? _____

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

Signature

Date

Terms of Acceptance

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal: To Locate, Analyze and Correct Spinal Interference to the Nervous System. The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference,) in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain and promote natural health. WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS. WE DO NOT OFFER TREATMENT OF CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS. WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S). THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!

I, having read the above statement and understanding it fully, do undertake chiropractic health care on this basis.

X _____
Signature Date

HIPAA COMPLIANCE SIGNATURE PAGE

Patient Name _____

Person/s you are releasing information to: _____

***Please choose one** _____ Any information _____ Billing information only

Person/s not to release information to: _____

Patient signature
OR
Guardian signature _____

Print Name if Guardian _____
Date _____

A copy of complete HIPPA policy is available by request.

_____ Refused to sign _____